

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-026173  
STATE FILE NUMBER

FILED JUL 28 1958

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 85

S. 300  
r. 1-57

1. PLACE OF DEATH a. COUNTY <b>Linn</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brookfield</b>		c. CITY OR TOWN <b>Brookfield</b> 05820	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cramer Conv. Home</b>		d. STREET ADDRESS (If outside, give location) <b>-</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>RICKER</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>M</b> <b>O</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer ret</b>		11. BIRTHPLACE (City and state or country) <b>Laclede, Mo.</b>	
13a. FATHER'S NAME <b>Not known</b>		14. NAME OF HUSBAND OR WIFE <b>Josie Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>486-12-7113A</b>	
17. INFORMANT <b>Gordon Bandow, Denver, Colo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO (b) <b>Hemiplegic arteriosclerosis</b> DUE TO (c) <b>331X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>indef.</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>1:45 a</b> Month <b>Jan</b> Day <b>1958</b> Year <b>1958</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Brookfield Linn Mo.</b>	
21. I attended the deceased from Death occurred at <b>1:45 a</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>H. D. Howell</b> (Deceased's title) <b>14-00</b>	
22b. ADDRESS <b>Brookfield Mo.</b>		22c. DATE SIGNED <b>7-24-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 26, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Brookfield, Mo.</b>
24. FUNERAL DIRECTOR <b>Wright Funeral Home, Brookfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7-26-58</b>	
26. REGISTRAR'S SIGNATURE <b>Katharine Johnson</b>		26. REGISTRAR'S SIGNATURE <b>dep.</b>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Harold B. Wright .....

Licensed Embalmer No. 3718 .....

P. O. Address Brookfield, Mo. .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.